UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF OHIO

WESTERN DIVISION

ERIC L. JEFFRIES,	:	
	:	
Plaintiff,	:	
vs.	:	Case No. C-1-02-351
	:	(Volume I)
CENTRE LIFE INSURANCE COMPANY, et al.,	:	
	:	
Defendants.	:	
	:	

Deposition of MICHAEL MCCLELLAN, MD, a witness herein, called by the defendants for cross-examination, pursuant to the Federal Rules of Civil Procedure, taken before me, Connie Dupps, a Registered Professional Reporter and Notary Public in and for the State of Ohio, at the offices of Hyde Park Internists, 2727 Madison Road, Cincinnati, Ohio, on Tuesday, October 14, 2003, at 3:00 PM.

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- - -

S T I P U L A T I O N S

It is stipulated by and between counsel for the respective parties that the deposition of MICHAEL MCCLELLAN, MD, a witness herein, called by the defendants for cross-examination, pursuant to the Federal Rules of Civil Procedure, may be taken at this time by the notary; that said deposition may be reduced to writing in stenotype by the notary, whose notes may then be transcribed out of the presence of the witness; and that proof of the official character and qualifications of the notary is

expressly waived.

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I N D E X

- - -

(Witness sworn.)

MICHAEL MCCLELLAN, MD

being by me first duly cautioned and sworn, deposes and says as follows:

CROSS-EXAMINATION

BY MR. ELLIS:

Q. Dr. McClellan, would you give the court reporter your full name, spelling your last name, please.

A. Michael McClellan, M C C L E L L A N.

Q. Dr. McClellan, have you been through the deposition process before?

A. Yes.

Q. You understand then if there is any time you don't understand one of my questions, or I misuse a medical term, or whatever, you'll straighten me out I hope?

A. I'll do the best I can, sir.

Q. In the event you feel any of your answers need an explanation, let me know. I would ask you to answer the question first and then give me any explanation you feel is necessary.

MR. ROBERTS: Objection.

Q. All right?

A. Okay.

Q. All right. Doctor, last night your office was kind enough to give me a copy of your records in the case of Eric Jeffries. Do you recall Mr. Jeffries as a patient?

A. I do.

Q. Can you tell me from your records, which I assume you have with you, when the first time you saw him would have been?

A. Actually I first saw Eric 5 years ago to the day today, October 14, 1998.

Q. What was the occasion of that visit, what brought him to you?

A. Mr. Jeffries had been under the primary care of Dr. Donald Nunlist-Young, and at that time was also under the care of several other specialists being evaluated for an, as yet undefined, illness, and he felt that he wanted another primary care opinion from a generalist. He had seen a few different specialists, but wanted someone other than Dr. Nunlist-Young to examine him and give another opinion on his illness.

Q. Okay. When you first saw him I assume you made a record of the history that he gave you?

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appropriately and whether there is obstruction to bile duct flow.

Q. Were you aware in April of '95 he was seen at both an Urgent Care and an emergency room for upper right quadrant -- right upper quadrant pain, whatever the proper term is?

MR. ROBERTS: Objection.

A. No, I was not.

Q. Do you know whether prior to the event he ever complained of sweats or being foggy, that is mentally foggy?

MR. ROBERTS: Objection.

A. Prior to when he became more acutely ill?

Q. Prior to the injection at all.

A. Not to my knowledge, no.

Q. Did he tell you he had a recurrent history of upper respiratory infections?

MR. ROBERTS: Objection.

A. No.

Q. Would any of that history have been of importance to you --

MR. ROBERTS: Objection.

Q. -- in evaluating this patient?

MR. ROBERTS: Objection.

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A. I have to answer that in a two part --

Q. Surely, any way you like.

A. -- answer. One is, of course, we get the best picture of a patient and their longitudinal health by having as complete a history as possible. I prefer that in every possible case when I'm evaluating a patient, new or old.

However, many of these historical facts that you bring up, assuming that they're true, I don't have records to indicate them, but I'm sure you do, really would not have changed my approach to his evaluation and my investigation had I known them, nor would they have changed my thought process and the way that I both approached his illness and have treated him since then.

And many of them have been evaluated even more fully with additional testing. For example, his right upper quadrant abdominal pain has been more fully evaluated since I've been caring for him and has been ruled out as having been an etiology that would explain his symptom complex.

Q. By saying it's been ruled out as an etiology, you're saying that the right upper quadrant pain isn't necessarily indicative of a disease process that's causing his overall problem?

MR. ROBERTS: Objection.

A. Let me say --

Q. In your words, yes.

A. -- in clarity, all of those areas that I mentioned that might be a cause for right upper quadrant abdominal pain, gallbladder disease, liver disease, disease of the colon, small intestine, and kidney. Those common organ systems that would be a cause for right upper quadrant pain have all been evaluated, looked at, and those organ systems, primary disease entities of those organ systems, are not the cause for Eric's current symptoms.

Q. Were you made aware of evaluations by Dr. Robert Reed, for example, at Wellington prior to your taking over his care?

MR. ROBERTS: Objection.

A. I have received records from Dr. Reed, not prior to when I first saw him, but eventually I did receive records from Dr. Reed.

Q. You have worked with Drs. Dunn and Luggen on and off on this case?

A. I have.

Q. Over the period of time?

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A. Yes.

Q. Between Dr. Dunn, Dr. Luggen, and yourself, at least to date, you have not come up with a definitive diagnosis for his symptoms; is that correct?

A. I feel that we have a definitive diagnosis as much as that diagnosis can be rendered.

Q. Okay. Let me stop you a moment then and ask you have you issued a report to Mr. Roberts or Mr. Jeffries concerning your opinions and the diagnosis that you believe is definitive at this point?

A. I have a copy here of a report that I have. Give me just a minute.

Q. Surely. To save you some time are you referring by chance to the affidavit that was drafted by Mr. Roberts for your signature?

A. Yes.

Q. Okay. Other than that have you had any other reports that you've issued in this case to Mr. Roberts or to Mr. Jeffries concerning your diagnosis?

A. I was deposed to give testimony before a special judge in Washington DC regarding this case

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and its potential relation to the hepatitis B vaccine that Mr. Jeffries received in a separate legal matter.

Q. You say potential hepatitis B relationship, you're saying that hasn't been definitively determined?

A. I can't -- I have to go back and listen to what I said, that's what's in question before the judge in Washington DC is whether or not his symptoms are directly and causally related to the hepatitis B vaccine. My personal opinion is that it is directly and causally related to the vaccine.

Q. When did you offer this testimony in Washington?

MR. ROBERTS: I'm going to state an objection for the record. Counsel is aware, he's been advised by the Department of Justice, that the proceedings in that action are not discoverable by him.

And I'll let this question be answered, but any further questions into the detail of that will come with the instruction not to answer.

A. I cannot give you the exact date. I don't

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have that in my records, but --

Q. Year?

A. -- it was within the last year.

Q. When was it that you came upon this definitive diagnosis for Mr. Jeffries' problem?

A. Well, once I began seeing Mr. Jeffries in 1998 and in working through, along with many other specialists, the possible list of multiple diagnoses to try to explain his symptom complex, it really took a period of about two years to completely and thoroughly, I think, evaluate all the possibilities. And Mr. Jeffries at his own expense went to see many different specialists around the country and outside of the country.

Every time another possible etiology was considered, I would do my own evaluation, but he would often seek out a second opinion from a noted specialist in that area to see if he could get a more definitive answer from a noted expert to rule in or rule out that possibility.

So only -- I would say I take a very cautious and measured approach to diagnoses of rare disorders and disorders which are not completely and fully understood in the mainstream medical

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literature, so our evaluation focused on -- focused on trying to exclude any other possible explanation for Mr. Jeffries' symptoms, and finding none, being convinced based on the time frame of the onset of his symptoms, that there was a likely trigger in the hepatitis vaccine that became the leading candidate for his cause of the symptoms.

And as I continue to see his illness evolve and continue to see more case reports and more literature in this area, I think that it's very consistent with his illness. There is no definitive test to prove that and so we can only use our best clinical judgment, that's my measured opinion at this time.

Q. And I appreciate that. My question was when did you come to this conclusion?

A. Approximately two years after my initial evaluation of him was when I became convinced that this was the -- this was the cause of his symptoms.

Q. So some time after you signed this affidavit from Mr. Roberts, which was done October of '99?

A. Well, I'll amend my answer then and say approximately one year after my initial evaluation

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of him, by October of '99.

Q. Okay. So this affidavit then reflects, even to date, your assessment of Mr. Jeffries' medical situation?

A. Right.

Q. In your affidavit you state that it is your opinion, irrespective of the inability to precisely diagnose Mr. Jeffries' condition, the effects of his illness make him unable to perform the material and substantial duties of his occupation as a merchant banker. That was one of your opinions, correct?

A. I would -- I would state that his illness is not defined in terms of a medical test abnormality. I would still conclude that he is unable to perform the duties of his occupation, that he is disabled at this time.

I would, were I to be giving a statement now, I would say that -- I would state that maybe in a different way and say that my opinion is that he has a postvaccinal encephalomyalgic process brought on by hepatitis B vaccine, and that we have painstakingly evaluated him for any other potential cause and found none.

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Q. So the diagnosis, if I understand you correctly, is postvaccinal, which would be after he had a vaccine, right?
A. Correct.
Q. Encephalo?
A. Myalgia.
Q. Myalgia?
A. Or encephalomyelitis, let's use that term, encephalomyelitis.
Q. Encephalomyelitis?
A. Postvaccinal encephalomyelitis.
Q. And encephalomyelitis would be an inflammation of the brain?
A. It is an inflammatory process involving the nervous system, the central nervous system in this case.
Q. Okay. An inflammation of the central nervous system?
A. Correct.
Q. What exactly is inflamed in the central nervous system?
A. Well, that's where Mr. Jeffries' diagnosis becomes difficult to quantitate in terms of a particular demonstrable area or set of nerves.

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There are PET scans and nuclear medicine SPECT scans, which I'm sure you've seen and reviewed, which showed some areas of abnormality in his cerebral cortex.
My own feeling is that the ability to define Mr. Jeffries' illness by either an anatomic scan or a biopsy which shows an abnormal area of muscle or nerve, or a blood test which reveals a specific antibody marker does not, in and of itself, make or break his diagnosis.
His diagnosis is, what we call, a clinical diagnosis, that means evaluating all of the facts, the history, the physical examination, the laboratory data, anatomic data that's available, putting it altogether in a way that makes sense, looking at as broad of a possible list of differential possibilities as one can generate, and then systematically trying to exclude or include a diagnosis that makes sense in a setting of his illness.
And whether or not he had an abnormality on an MRI scan that said these nerves are inflamed or not, whether or not he had an abnormal SPECT scan or PET scan would not, in and of itself, tell me

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that he did not have this illness and would not also make the diagnosis for me. It's a clinical diagnosis.
Q. Does -- I'm sorry. Does this illness have a name that is recognized in the general medical community?
A. Not that I'm aware of. There may be experts who are writing on this who have decided on a particular term for this illness, but it is -- there is a body of literature that does describe symptoms just as what Mr. Jeffries has following hepatitis vaccination.
Q. Case reports?
A. Case reports, correct.
Q. And then there are studies that definitively identified the cause and effect relationship or even identified exactly what the disease is, correct?
MR. ROBERTS: Objection.
A. I'm not aware of a designed study to undertake that question.
Q. In the majority of cases that have been reported in this postvaccinal development of symptoms, there has either been a development of

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frank rheumatoid arthritis, which is an identifiable disease, correct?
MR. ROBERTS: Objection.
Q. That's one of the things that people have related, at least, in the literature by case study, correct?
MR. ROBERTS: Objection.
A. The case reports that I have read talk about rheumatoid arthritis like syndrome. I don't -- I don't know that the vaccine itself is said to cause true rheumatoid arthritis.
Q. In the case studies that you read, did the patients who had symptoms of significance also have a hepatitis B antibody that was discoverable?
A. Hepatitis B surface antibody?
Q. Yes.
A. You mean prior to being vaccinated or after vaccination?
Q. No, after, when they were being evaluated for the subsequent symptoms.
A. I don't know the answer to that. I do know that some case reports were following only one injection of the series of three and some involved more than one vaccination.

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your question.
Q. I think I'm with you. What I'm asking you is this. Are you suggesting that people who have a somatoform disorder are manufacturing symptoms as opposed to feeling them?
A. No, that's what I'm trying to differentiate between. People with somatoform disorders feel that they have particular symptoms. They have feelings of symptoms.
They don't come in and say -- generally in the patients that I see, for example, they come in with abdominal pain. They don't come in and say I think I have a tumor in my belly, although that may be one of their concerns, but they feel that they have a particular subjective complaint in a particular area.
Q. Or multiple subjective complaints that they have focused on and continue?
A. Um-hmm, some times.
Q. In the normal course of events, a person who has a hepatitis B shot, for example, or any type of immunization can have a reaction to the immunization which is generally flu-like symptoms in a short duration, would you agree?

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A. True.
Q. If someone however focuses on that normal occurrence, continues to focus on it, they can intermittently recreate those same body of symptoms, correct, not saying voluntarily, I'm saying psychogenically?
A. There is a possibility that symptoms could be psychogenic rather than true physical symptoms.
Q. And a person who has either obsessive compulsive disorder or obsessive compulsive traits will focus on these ailments and seek the diagnosis, would you agree, he can become obsessed with getting a diagnosis to explain his symptoms that are psychogenically created?
A. If someone does have obsessive features and also has a somatization disorder as a separate, they're not one in the same.
Q. I agree.
A. That is if they have both of those conditions together, then one might see someone become very persistent and obsessed with trying to come up with an explanation for their symptom complex.
Q. That would be one potential explanation

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for Mr. Jeffries' peculiar history, would it not?
MR. ROBERTS: Objection.
A. Having a fair number of obsessive compulsive patients in my practice that I see, and having seen some patients with somatization disorder as well, I would have to say that Mr. Jeffries' presentation would be atypical in the patients that I see.
Q. Let me ask you this. Would Mr. Jeffries' presentation be atypical from a physical standpoint as well?
A. I don't understand your question. Sorry.
Q. Surely. You said as far as potential or considering a potential diagnosis of somatoform disorder with some obsessive traits his presentation to you would be atypical of a patient with that combination, we're right so far, right?
A. Correct.
Q. My question to you is from a patient coming into you with a physical ailment of some sort, Mr. Jeffries' presentation is also atypical?
MR. ROBERTS: Objection.
A. Well, if one believes in the entity of a vaccine-induced autoimmune process that has caused

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his symptoms, that's a rare process, but I'm not sure that it's atypical for that process.
Q. How many patients like Mr. Jeffries do you have, Doctor?
A. I don't have any others, thank the Lord for that.
Q. How many patients do you have that have gone to the extent of using their own funds to fly to England, Brussels, Ottawa, Milwaukee, California, Oklahoma, Alabama, Massachusetts, Florida, all for purposes of seeking a diagnosis?
A. None. And also say that none of the other patients that I have who I do treat for obsessive compulsive disorder, and who I see with somatization disorder are ever that persistent or that willing to go to that extent, or to risk potential loss of his diagnosis that we have taken so much pains to go to to try to narrow the scope of, by going back out on another limb to chase down another possibility.
Only ones who really are interested I would suggest -- I would say that that strikes me as someone who really wants to be well, not someone who wants to continue to focus on his symptoms, which people with somatization disorder prefer to do.

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Those people are not felt to have a underlying psychiatric DSM-IV diagnosed criteria-meeting psychiatric illness, otherwise they would not meet the diagnostic criteria for fibromyalgia.

Q. Because fibromyalgia by definition means you can't have a psychiatric explanation for your symptoms?

A. Exactly. And so I would argue in Mr. Jeffries' case that -- and this is where, I suppose, it comes down to what different people want to argue, but my feeling after seeing him for the last five years is that he has real pain, that the pain and the cognitive deficits are disabling him, and that the basis of that is not a psychiatric disorder, but a medical physiologic physical problem.

And the best explanation I have for that, given everything that I've done and everything I've looked at and listened to, is that there was a trigger of his immune system caused by the hepatitis B vaccine. If I thought that he had a psychiatric diagnosis, I could not make the other diagnosis.

Q. I understand, Doctor, what your feeling is

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having treated this fellow for five years. The question is can that feeling be substantiated in some way that makes it understandable in the general science of medicine?

MR. ROBERTS: Objection.

A. Well, I'm not sure what more I can say to you other than what I already have, that's the frustrating part of Eric's illness.

Q. We don't know?

A. Have no silver bullet, no magic marker, no blood tests, no scan that I can use to, use your own words, substantiate the diagnosis. It's a clinical diagnosis.

Q. We're not in disagreement, a person with somatoform disorder has real pain, right?

A. Correct.

Q. It's just that instead of being caused by the body and received by the mind, it's being caused by the mind and then received back?

A. Correct.

Q. The pain is just as real, the symptom is just as real?

A. The symptom is just as real.

Q. In fact, there's been psychogenic

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pregnancies where a woman has gone all the way through with a bloated belly and everything else and went through delivery and nothing was there?

A. I haven't heard of that, but if you say so.

Q. So it's not a question of whether or not we believe Mr. Jeffries' symptoms necessarily. The question is can we establish by some means that is understandable what is physically wrong with him or what is psychologically wrong with him that causes him to experience these symptoms, right?

A. I think that really is the crux of it, isn't it?

Q. Right. And the crux of the question is we can establish, at least from neuropsychological testing, some explanation for it that accounts for the symptoms, whereas on the physical side we cannot do that?

A. Well, I'm not an expert in neuropsychiatric testing.

Q. We'll let you assume that that's true.

A. So I will say that I utilize neuropsychiatric testing occasionally, but I don't rely on it as a complete and infallible diagnostic

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test.

Q. No argument. Question is on the one side of the ledger we at least have some means of testing, measuring, that can be repeated, whereas on the physical side of the ledger that's missing?

MR. ROBERTS: Objection.

A. I guess I wouldn't completely agree with that. I would say the right-sided physical exam findings that he has developed over time are an evolutionary thing that he did not present with initially, and so there has been some physical examination, evidence, of some decline in function.

Q. Let me ask you this --

A. Unless you were to suggest that his problems with his right side are not real and that he is faking that symptom, that finding.

Q. Let me ask you this. Have these right-sided symptoms, assuming them to be real, assuming them to be exactly as you find them, and assuming that they develop some what now, six years after this injection, are they disabling him in some way from sitting at a desk and being a banker?

A. Not in and of themselves. Again, I think they are just another manifestation of the totality

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S T I P U L A T I O N S

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I N D E X

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MR. ELLIS: Doctor, you consider yourself still under oath, don't you?

THE WITNESS: I certainly do.

MICHAEL MCCLELLAN, MD

being by me previously cautioned and sworn, deposes and says as follows:

CROSS-EXAMINATION (CONTINUED)

BY MR. ELLIS:

Q. When we left off last time, Dr. McClellan, we were discussing a number of different potential labels to put on Mr. Jeffries' difficulties, which included myalgic encephalomyelitis, chronic fatigue syndrome, wasn't there a third, autoimmune cerebritis?

MR. ROBERTS: Objection. Go ahead.

A. I would not call it an autoimmune cerebritis. I think he has an autoimmune-mediated process, which contributes to his muscle pain, weakness, cognitive dysfunctions, and that's on the basis of an immune reaction to the hepatitis vaccine.

And different specialists, different physicians, have called it or used -- called it different things, used different terminologies, but

that's the underlying process.

Q. This is the working hypothesis that you currently have?

MR. ROBERTS: Objection.

A. That's my feeling as to his diagnosis.

Q. You recall Dr. Hyde, for example, suggested that he had a parkinsonian appearance, and movement, and so forth?

MR. ROBERTS: Objection.

Q. Do you recall that?

MR. ROBERTS: Objection.

A. I believe he said that he had some parkinsonian features, but I would have to look at his note to see his exact wording.

Q. All right. In your records of March of 2001 you received a referral letter sent to Dr. Hyde by a Dr. Fernandez from Canada?

A. I'm sorry, what was the date on that?

Q. You were carbon copied on the letter that is dated March 14th. It appears you received it March the 19th perhaps of 2001.

A. Yes, I have it.

Q. Okay. In the letter, if you look to the second page, in summary the good doctor found that

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And I certainly considered that along the way. And many of the consultants who Mr. Jeffries saw at various times I'm sure considered that as a part of his differential list of possible explanations.

Q. Do you still believe that the psychiatric aspect of his disease may be a major factor in the functional irritation to his life or the functional limitations of his life?

MR. ROBERTS: Objection.

A. I'm sorry. You'll have to rephrase that for me or give that to me again, what your question was.

Q. Yes. Do you still believe that the psychiatric overlay or aspect of his illness, if it's an illness, may be -- may still be the primary factor in the limitations that he's experiencing?

MR. ROBERTS: Objection. He's testified that it's a medical illness. What are you trying to suggest?

A. No, what I would suggest is that it is not the factor. I would clarify your question, if I may.

Q. Please.

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A. To say that, because I think I said before, that I considered that as a possibility, but my position and my feeling is that Mr. Jeffries' symptoms are not psychogenic, do not relate to a primary psychiatric disorder, be it somatization or obsessive compulsive disorder, but that based on many years and multiple interactions with this man, that I think his symptoms relate to a primary medical autoimmune-related disorder that was instigated and began by his hepatitis B vaccine.

Q. I understand that that is your belief. Are you suggesting that whether or not that, in fact, exists, that the impact of the depression that you've occasionally observed or other psychiatric problems, are not driving the limitations --

MR. ROBERTS: Objection.

Q. -- and experiences?

MR. ROBERTS: Objection.

A. Let me put it another way and see if this gets to the point that I think you're trying to make, which is is there also a superimposed depression or other psychiatric disorder, which may coexist with the medical condition, am I correct?

Q. That's where I'm heading, yes.

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A. Let me say this, at times Mr. Jeffries has certainly appeared depressed. At times I have even suggested that he consider antidepressant therapy for episodic depression. At times he has been extremely focused on his symptoms to where he wants to come to a definitive diagnosis and attempt a resolution of his illness.

I find that to be entirely appropriate for somebody who, at least as I have been told, was a very high functioning individual, had a wonderful family life where he was involved with his children's activities, enjoyed good health, and suddenly became unable to participate in the routine activities of his daily life and his work.

If that were to happen to me, I would certainly experience a reactive type of depression and I might become very focused, in fact one might say obsessed, with trying to come to an understanding of why this has happened to me.

I don't consider that to be somatization disorder. I don't consider that to be obsessive compulsive disorder. Nor do I consider that to be primary depression. Those are secondary to what his underlying fundamental medical problem is and

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that's -- and that's the crux of this issue to me.

Q. If someone, as you suggest, is leading a relatively normal life, high function, develops an illness and then becomes focused or obsessed on the illness, isn't it possible in your experience that by focusing on the illness they perpetuate it?

MR. ROBERTS: Objection.

A. I have seen and take care of a good number of people in my practice with obsessive compulsive disorder, and some of them have somatization disorder as well. I have never seen in any of them an acute onset of a problem whereby there have not been, I'll call it, premorbid, or prior to the acute defining incident, premorbid episodes or facets of their behavior which suggested this to be in the background of their -- of their psyche, of their psychological makeup, to where they were predisposed to having some problems in this area.

Now, I did not know Mr. Jeffries before his illness, but I think it would be relatively easy to go back through his previous medical records, which I personally have not done, but it would not be a huge burden to go back and look and see if he had multiple episodes of somatization or obsessive